



Medical Treatment

Self-Insurance Claims Adjudication Guidelines

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Authorization and Denial of Treatment

[WAC 296-15-425](#)

For all treatment requiring authorization under [WAC 296-20-03001](#), self-insurers must notify the worker in writing within five days of the decision to authorize or deny the requested treatment.

This notification must be provided using the [Treatment Decision](#) template (form F207-226-000).

Acupuncture

[WAC 296-23-238](#)

Authorization Requirements

Effective June 1, 2019, acupuncture may be authorized for low back pain when related to an accepted condition on a claim. Acupuncture should not be covered for treatment of any other conditions.

Prior authorization is not required for acupuncture treatment, but treatment should only be covered if the referral is made by the attending provider.

Up to 10 acupuncture visits may be covered over the lifetime of the claim. Treatment should be provided with a licensed Acupuncturist, also called an East Asian Medicine Practitioner.

Documentation Requirements

For continued authorization to be provided, there must be documented improvement in the worker's function over the course of treatment. The Oswestry Disability Index (ODI) and 2-item Graded Chronic Pain Scale (GCPS) functional scores must be used to assess the worker's improvement in pain and function at baseline, middle/fifth visit, and at treatment end.

All reports should include the following information:

- Summary of subjective complaints.
- Objective findings.
- Treatment plan focusing on functional improvement.

The final visit report must also include the reason for discharge.

Ambulance Services

[RCW 51.36.020\(1\)](#)

Emergency Transport

Ambulance services are paid when a worker's injury is so serious that the use of any other method of transportation is contraindicated.

The insurer pays for ambulance services to the nearest place of proper treatment. The facility must be generally equipped to provide the needed medical care. A facility is not considered a place of proper treatment if no bed is available when inpatient medical services are required.

Air ambulance services, either by helicopter or fixed wing aircraft, are paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that could not have been provided by ground ambulance, or
- The point of pickup is inaccessible by ground vehicle, or
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

Nonemergency Transport

Only medical providers may arrange for nonemergency ambulance transportation. Workers may not arrange nonemergency ambulance transportation.

Nonemergency transport by ambulance is appropriate if:

- The worker is bed-confined, and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated. Bed-confined means the worker is unable to:
 - Get up from bed without assistance,
 - Ambulate, or
 - Sit in a chair or wheelchair
- The worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

An ambulance can also be used to transport workers to:

- Another facility for treatment.

- Their own city if injured and treated in another city.
- Scheduled, regularly-provided diagnostics or treatment.
- An independent medical examination or a consultation.

Payment is made in accordance with the appropriate fee schedule.

Amputation and Prosthetics

[RCW 51.36.020](#), [WAC 296-20-1102](#)

The insurer will authorize and pay for amputation, prosthetics, and orthotics when needed by the worker and substantiated by the attending provider. The provider must obtain prior authorization, and the amputation, prosthetics, and orthotics must be appropriate and medically necessary to treat the worker's accepted condition.

There are three types of claims involving amputation and prosthetics:

- A traumatic amputation, where a catastrophic incident either caused or necessitated the amputation of a limb or appendage.
- An amputation as a result of complications of the injury or occupational disease itself or from complications caused by preexisting or unrelated illness.
- An injury that caused damage to an artificial limb. (Once the repair/replacement is completed and certified by the attending provider as acceptable, no additional prosthetic services should be allowed under the claim.)

Prosthetics

With any amputation, there will be post-operative casting applied to the remaining portion of the limb (stump). The initial prosthesis is a temporary one and will last from three to nine months. Each replacement will last about twice as long as the previous replacement, up to a long-term replacement every three to five years. Although stump shrinkage may occur at any time, the majority of shrinking will occur during the first three to nine months.

Stump Socks and Sleeves

Reasonable quantities of stump socks and sleeves should be authorized. For example, a moderately active amputee may need seven pairs of prosthetic socks and/or two sleeves approximately every six months. More socks and/or sleeves will be needed to prevent skin breakdown for extremely active amputees and during warmer weather.

Additional or Backup Prosthetics

The purchase of an original prosthetic and a backup prosthetic can be allowed if both are medically necessary. Normally, a worker can get by with just one prosthesis by using an old prosthesis for backup when the good one needs to be repaired.

Depending on the worker's job and medical documentation, there may also be situations when a work prosthesis and a second one, for home or social use, should be allowed. Authorizations for additional or backup prostheses must be based on medical need.

Repair and Replacement

The insurer is responsible for repairing or replacing prosthetics for the lifetime of the worker who lost a limb as a result of an industrial injury, as long as the damage is not caused by negligence.

- The insurer will repair or replace damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices which were originally furnished by the insurer.
- The insurer will repair or replace prosthetics when needed due to normal wear and tear or anatomical changes and medically necessary.

The insurer is not responsible for replacing lost or stolen insurer-provided prosthetics or special equipment. There are no provisions for lost or stolen prosthetics in [WAC 296-20-1102](#).

Permanent prostheses should last from three to five years, depending on the activity level, including the job of the worker. Most manufacturers recommend that prosthetists replace the components in a limb at three-year intervals to prevent fractures and part failure. Prosthetists try to repair limbs to keep them functional, but there are times when they must be replaced. If parts are worn out and dangerous, a new limb will be requested. Most parts carry a manufacturer's warranty of three months to one year. Satisfaction and workmanship warranties vary with each facility.

When receiving a request for prosthetic replacement, there are several factors to consider:

- Very active amputees usually need replacements or major modifications every two to three years. Therefore, the length of time since the previous replacement should be checked.
- The use of multiple prosthetic socks or those of extra thick ply would indicate excessive stump shrinkage. This may require relining the socket, a new socket, or replacing the prosthesis.

- Only two check sockets are allowed per prosthetic construction. A check socket is a temporary trial socket to check the fit. In some cases, x-rays may be required to determine where bone is located to avoid pressure points, which can lead to skin ulcers.

Repairing or Replacing Prosthetics on Closed Claims

It is not necessary to reopen a closed claim to repair or replace a prosthesis or authorize socks or sleeves which were originally supplied under the claim. (See [WAC 296-20-124](#)(4).)

Attending Providers

[RCW 51.36.010](#), [WAC 296-20-065](#), [WAC 296-20-01010](#), [WAC 296-20-01002](#)

[RCW 51.36.010](#) gives workers the right to choose the provider who will treat their industrial injury or occupational disease. All Washington State providers of the following types must be in L&I's Medical Provider Network to give ongoing care for injured workers:

- Physicians
- Chiropractors
- Naturopathic Physicians
- Podiatric Physicians
- Advanced Registered Nurse Practitioners (ARNPs)
- Physician's Assistants
- Dentists
- Optometrists

These providers can sign accident forms, provider initial reports and certify time-loss compensation. Other provider types, while required to have an L&I provider number, are not required to join the network (for example, out-of-state providers, Physical and Occupational Therapists, and psychologists). To find providers who have been approved into the network, see <https://secure.lni.wa.gov/provdir/>.

The online directory is updated each business day. It also shows provider types not required to join the network.

An injured worker often receives initial treatment through a hospital emergency room or urgent care clinic. The injured worker will usually be referred to another provider for their follow-up care. Formal notification of a transfer of provider is not necessary in this situation. Non-network providers can be paid for the initial visit only. For a definition of the initial visit, see [WAC 296-](#)

[20-01002](#). After the worker's attending provider has been established, all transfers from one provider to another must be approved by the insurer.

Transfer of Providers

[RCW 51.36.010](#) gives workers the right to choose the provider who will treat their industrial injury or occupational disease. This provider becomes the attending provider (AP) of record. The AP must be:

- An approved provider in L&I's Medical Provider Network if treating in Washington State.
- A provider with an active L&I provider number if treating outside the state.
- Licensed in the state in which they are practicing.
- Conveniently located.
- Qualified to treat the area of injury or disease.

All workers with open claims are required to get ongoing treatment from a provider in the Medical Provider Network. If a worker is treating with a non-network provider in Washington State, the insurer will need to assist them in finding and transferring to a network provider for ongoing treatment. Use the following tools:

- [FindADoc](#) to assist workers in finding a network provider.
- [Transfer of Attending Provider Form for Self-Insured Workers](#)

A worker may transfer to a new AP during the course of treatment; however, [WAC 296-20-065](#) requires that all transfers must be approved by the insurer. Adequate time should be allowed for an appropriate treatment program prior to transfer of AP. Approval should be given for a transfer request unless there is a legitimate reason for denial. Denying a request to transfer AP **should not** be a casual decision. The decision to deny should be justified and well-documented in a letter to all parties.

Transfer Without a Specific Request

If a worker or provider has not specifically requested a transfer, but a transfer appears to be indicated from other information in the claim, the insurer should clarify the change with the worker and/or provider. Information that a worker has changed their AP may come in a number of ways (phone call, medical reports or bills from a provider other than the AP of record, etc.).

Transfer of Attending Provider for Surgery

When surgery is authorized or a worker is referred to another provider for surgery, the surgeon should be listed as the AP. Many surgical procedures have a flat fee (also called global surgical or follow-up) period. A flat fee period is a specific number of days following surgery when the surgeon provides all follow-up care. Postoperative care is included in the surgical fee as a global surgical fee package.

An exception to this rule is when the worker lives far enough away from the surgeon to make aftercare by the surgeon impractical. If so, care is not transferred to the surgeon. Arrangements should be made before the surgery for the worker to receive postoperative care from the local AP. The doctors involved are to determine the apportionment of the total fee for the flat fee period.

Required Transfer of Attending Provider

[WAC 296-20-065](#) allows the insurer the right to require a worker to select another provider under the following conditions:

- A more conveniently-located AP is qualified to provide the necessary treatment.
 - There should be documentation from the AP that travel would delay recovery. The worker should not be required to change to a closer AP just because of distance. See Travel Expenses in the [Miscellaneous Claim Issues](#) chapter regarding travel reimbursements.
- The AP fails to observe and comply with the department rules.
- The worker is receiving time-loss compensation benefits but isn't showing reasonable progress toward returning to work.
- The worker requires specialized treatment which the AP is not qualified to render or is outside the scope of the AP's license to practice.
- The insurer finds a transfer of AP to be appropriate and has requested the worker to select another AP in accordance with this rule. The insurer may select a new AP if the worker unreasonably refuses or delays in selecting another AP.
- In cases where the AP is not qualified to treat each of the worker's accepted conditions. This doesn't preclude concurrent care ([WAC 296-20-071](#)) where indicated.

Transfers will be authorized for the above reasons or where the insurer in its discretion finds that a transfer is in the best interest of successfully returning the worker to gainful employment.

No transfer will be approved to a consultant or special examiner without the approval of the AP and the worker.

Autologous Blood Transfusions

Authorization is not required for the collection and storage of a worker's blood prior to a planned surgery. The Washington State Blood Bank requires a physician's prescription.

Prior authorization is required for oral iron and/or vitamin C products prescribed by an attending provider to prevent anemia as a result of the blood being drawn. The use of these dietary supplements should begin one month before the first donation and continue for at least six months after the first donation.

Biofeedback

[WAC 296-20-03001](#)(10), [WAC 296-21-280](#)

Biofeedback treatment requires an attending provider's prescription and must be pre-authorized. The self-insurer must communicate in writing the treatment authorization or denial as outlined in [WAC 296-15-425](#). Biofeedback is not a cure-all and does not work equally well for all workers. Whether or not biofeedback is an appropriate treatment technique is determined by an initial evaluation.

Biofeedback treatment uses concentration and relaxation techniques, as well as electronic equipment, to teach workers how to control voluntary physiological responses. A physiological response, such as muscle tension or skin temperature, is measured, and information about the response is immediately provided to the worker. In this way, the worker can learn how his or her body is reacting, and in many cases, how to control different physiological systems to better control pain and other symptoms.

Biofeedback may be very helpful in the treatment of stress-related disorders, such as tension headaches, migraine headaches, hypertension, pain management, circulatory problems, and general anxiety.

A typical session lasts 40 to 50 minutes, during which the worker may try different strategies to learn to control the specific body system. Biofeedback usually takes one or two sessions per week. The overall length of treatment depends on the medical diagnosis and the worker's progress.

Chiropractic Treatment

Introduction

[RCW 51.36.015](#) permits workers to seek chiropractic care and evaluation. Chiropractic doctors must be licensed under RCW 18.25. Chiropractic is defined by [RCW 18.25.005](#):

“Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.”

Chiropractic Scope of Practice

Chiropractic is defined under [RCW 18.25.005](#). Chiropractors may be attending providers on claims for extremity conditions. Chiropractors may:

- Diagnose all joint dysfunction and musculoskeletal disorders, including those originating in the extremities.
- Treat back injuries with spinal adjustments and therapies. Extremity joint manipulations can be done along with the spinal adjustment. There is no separate charge allowed for it.

Chiropractic X-rays

[WAC 296-20-121](#)

X-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization when medically necessary.

- No payment will be made for excessive or unnecessary x-rays.
- Repeat or serial x-rays may be performed only upon receipt of adequate clinical justification to confirm changes in the worker’s condition.

Chiropractic Treatment

Chiropractic treatment is conservative care and usually consists of spinal adjustments and extremity joint manipulations. Chiropractors may bill only one chiropractic care visit per day. Chiropractic treatment may not include the application of sound, diathermy, or electricity, but may include:

- The use of heat, cold, water, exercise, massage, trigger point therapy, traction, and light.
- Certain types of supportive devices, such as cervical collars, lumbosacral supports, heel lifts, and under certain conditions, orthotics, such as arch supports, or spinal pelvic stabilizers.
- Patient education in daily living, exercise, and return to work; counseling on diet, hygiene, sanitation, and preventative measures.
- Referral to physical therapy, licensed massage therapy, or other medical specialists.

Chiropractic Diagnoses and Billing

Chiropractors may diagnose and bill for any musculoskeletal conditions and are no longer limited to diagnosing only specific International Classification of Diseases (ICD-10) codes. The chiropractor must provide the reports required by [WAC 296-20-01002](#) and [WAC 296-20-06101](#), including documentation that the:

- Objective findings support the subjective complaints.
- Diagnosis being treated is related to the injury on a more probable than not basis.
- Treatment recommended has a clear goal and is time-limited.
- Progress reports indicate that the treatment plan has been effective and supports continued and curative and/or rehabilitative treatment.

Chronic Pain Management Program

[WAC 296-20-12050](#)

Injured workers eligible for benefits under Title 51 RCW may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a structured, intensive, multidisciplinary program (SIMP). Detailed rules for SIMP programs are available in the [Medical Aid Rules and Fee Schedule Chapter 34](#).

All SIMP services require a referral from the worker's attending provider. A nurse consultant, claim manager, or insurer-assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider.

Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain. The self-insurer must communicate in writing the treatment authorization or denial as outlined in [WAC 296-15-425](#).

All SIMP services require:

- Prior authorization by the insurer, and
- A referral from the worker's attending provider.

An occupational nurse consultant, claim manager, or insurer-assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider.

SIMP

A SIMP is defined as a chronic pain management program with the following four components:

S—Structured means care is delivered through regular, scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed health care practitioners. Workers follow a treatment plan designed specifically to meet their needs.

I—Intensive means the treatment phase is delivered on a daily basis, 6-8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs.

M—Multidisciplinary (interdisciplinary) means that structured care is delivered and directed by licensed health care professionals with expertise in pain management in **at least** the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits.

P—Program means an interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Requirements the Worker Must Meet

A SIMP should only be authorized if the worker:

- Has had unresolved chronic pain for longer than three months despite conservative care, and
- Has one or more of the following conditions:
 - Is unable to return to work due to chronic pain.
 - Has returned to work but needs help with chronic pain management.
 - Has significant pain medication dependence, tolerance, abuse, or addiction.

Requirements the SIMP Provider Must Meet

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all the requirements listed in this section. They must:

- Meet the definition of a Structured Intensive Multidisciplinary Program.

- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF). Providers must maintain CARF accreditation and provide L&I with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed.
- Provide the services described in each phase.
- Communicate with providers who are involved with the worker's care.
- Ensure care is coordinated with the worker's attending provider.
- Inform the insurer whether the worker stops services prematurely, has unexpected adverse occurrences, or does not meet the worker requirements.
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment.
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed.
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Phases of an approved SIMP

Evaluation Phase

Only one evaluation is allowed per authorization. It can be conducted over one or two days. This phase occurs before the Treatment Phase and includes treatment plan development and a report.

The Evaluation Phase includes all of the following components:

- A history and physical exam, along with a medical evaluation by a physician. ARNPs and PA-Cs can perform the medication portions of the evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities.
- Review of medical reports and reports, including diagnostic tests and previous efforts at pain management.
- Assessment of any important associated conditions (unrelated conditions) that may hinder recovery, such as opioid dependence and other substance use disorders, smoking, significant medical health disorders, and unmanaged chronic disease.

- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs.
- Psychological and social assessment by a licensed clinical psychologist using valid tests and instruments.
- Identification of the worker's family and support resources, reasons and motivation for participation and improvement, and factors that may affect participation in the program.
- Assessment of pain and function using valid tests and instruments. It should include current levels, future goals, and estimated treatment time to achieve these goals for each of the following areas:
 - Activities of Daily Living (ADLs)
 - Range of Motion (ROM)
 - Strength
 - Stamina
 - Capacity for an interest in returning to work
- If the insurer has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity.

The evaluation should address whether the worker meets the requirements for the program and can fully participate. If the worker meets the requirements and the SIMP provider recommends he or she move on to the Treatment Phase, the provider must send a report and treatment plan to the insurer.

If the worker does not meet the requirements or cannot fully participate, the SIMP provider must send the insurer a report explaining what requirements weren't met and goals the worker must meet before participation in the program.

If the worker has unrelated conditions that prevent participation in the Treatment Phase, the SIMP provider must either treat the worker or provide treatment recommendations to the attending provider and insurer.

Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days, excluding weekends and holidays. This may be adjusted depending on individual needs and progress toward treatment goals. Each treatment day lasts 6-8 hours. Services are coordinated and provided by a team of

physicians, a psychologist, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators.

Treatment must include the following elements:

- **Graded exercise** – Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence.
- **Cognitive behavioral therapy (CBT)** – Individual or group CBT with the psychologist, psychiatrist, or psychiatric ARNP.
- **Coordination of health services** – Coordination and communication with the attending provider, insurer, family, employer, and community resources as needed to accomplish the goals set forth in the treatment plan.
- **Education and skill development** on the factors that contribute to pain, responses to pain, and effective pain management.
- **Tracking of pain and function** – Individual medical assessment of pain and function levels using valid tests and instruments.
- **Ongoing assessment** of unrelated conditions, medication tapering, and clinical assessment of progress toward goals. Opioid and mental health issues can be treated concomitantly with pain management treatment.
- **Performance** of real or simulated work or daily functional tasks.
- **When a vocational referral has been made**, vocational services with return to work goals are needed in accordance with the Return to Work Action Plan. SIMP vocational services may include instruction regarding workers' compensation requirements.
- A **discharge care plan** for the worker to continue exercises, cognitive and behavioral techniques, and other skills learned during the Treatment Phase.
- A **report** at the conclusion of the Treatment Phase that addresses all the following questions:
 - To what extent did the worker meet his or her treatment goals?
 - What changes, if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?
 - What changes, if any, have occurred in the worker's pain level and functional capacity as measured by valid tests and instruments?

- What changes, if any, have occurred in the worker's ability to manage pain?
- What is the status of the worker's readiness to return to work or daily activities?
- What is the status of progress in achieving the goals listed in the Return to Work Action Plan, if applicable?
- How much and what kind of follow up care does the worker need?

If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the insurer may authorize resuming or restarting the SIMP if recommended by the SIMP provider.

Follow Up Phase

The Follow Up Phase may last for up to six months after the Treatment Phase has concluded, so long as the claim remains open. This phase isn't a substitute for and cannot serve as an extended Treatment Phase. However, authorization for the Treatment Phase includes authorization for the Follow up Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase.
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life.
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

The activities of the Follow Up Phase may occur at the original SIMP clinic (clinic-based) or at the worker's home, workplace, or health care provider's office (community-based). This allows maximum flexibility for worker's whose needs range from intensive, focused follow up care at the clinic to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

Follow up services are payable as face-to-face and non-face-to-face services.

Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers. Non face-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other health care providers to coordinate care in the worker's home community.

Services are subject to the following limits:

- Face-to-face services: up to 24 hours allowed, with a maximum of 4 hours per day.
- Non face-to-face services: up to 40 hours allowed.

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in the community, activity levels, and support systems.
- What was done during the Follow Up Phase.
- What resulted from the follow up care.
- Measures of pain and function using valid tests and instruments.

Summary reports must be submitted at one and three months.

The Follow Up Phase should include evaluation and assessment activities, treatment activities, and community care coordination, and support activities.

Evaluation and assessment activities include:

- Assessing pain and function with valid tests and instruments.
- Evaluating whether the worker is complying with the home and work program that was developed at the conclusion of the Treatment Phase.
- Evaluating the worker's dependence, if any, on opioids and other medications for pain.
- Assessing unrelated conditions and psychological status, especially as related to reintegration in the workplace, home, and community.
- Assessing what kind of support the worker has in the workplace, home, and community.
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist.

- Adjusting the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work.
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase.
- Teaching new techniques or skills that were not part of the original Treatment Phase.
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the attending provider, surgeon, other providers, the claim manager, insurer-assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain.
- Making recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources.
- Holding case conferences with the interdisciplinary team of clinicians, worker's attending provider, and/or other individuals closely involved with the worker's care and functional recovery.

When determining what follow up services the worker needs, SIMP providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24-hour limit on face-to-face services.
- If a SIMP provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24-hour time limit, and the trip must be preauthorized for mileage to be reimbursed.
 - Lodging and meals are not reimbursable.
 - Actual travel time isn't included in the 24-hour limit.
 - When requesting authorization for mileage, the SIMP provider must explain the reason for the visit and how it will benefit the worker.

- The required Follow Up evaluations must be done face-to-face with the worker and are subject to the 24-hour limit on face-to-face services.
- When the SIMP provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately.
- Authorized Follow Up services can be provided, even if the worker has surgery during the follow up period.
- If a SIMP provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization.

Worker Responsibilities

An injured worker must make a good faith effort to comply with the treatment plan prescribed by the SIMP provider. To successfully complete a SIMP, the worker must meet the following requirements:

- Be medically and physical stable enough to safely tolerate and participate in all physical activities and treatments that are part of the treatment plan.
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of the treatment plan.
- Agree to be evaluated and comply with treatment prescribed for any associated conditions that hinder progress or recovery.
- Attend each day and session that is part of the treatment plan. Sessions may be made up if the provider feels they don't interfere with the worker's progress toward treatment goals.
- Cooperate and comply with the treatment plan.
- Not pose a threat or risk to himself or herself, to staff, or to others.
- Review and sign a participation agreement with the provider.
- Participate with coordination efforts at the end of the Treatment Phase to help transition back to the home, community, and workplace.

Vocational Services and SIMP

The insurer will determine, based on the facts of each case, whether to request a vocational referral prior to authorizing participation in a SIMP. The insurer may assign a vocational

counselor if the worker needs assistance in returning to work or becoming employable ([WAC 296-19A-020](#)). The insurer will not make a vocational referral when the worker:

- Is working.
- Is scheduled to return to work.
- Has been found employable or not likely to benefit from vocational services.

Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with SIMP treatment and the insurer assigns a vocational counselor.

The Return to Work Action Plan provides the focus for vocational services during a worker's participation in a chronic pain management program. The plan may be modified or adjusted during the treatment or follow up phase as needed.

At the end of the program, the outcomes listed in the Return to Work Action Plan must be included with the treatment phase summary report. The insurer-assigned vocational counselor will work with the SIMP vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

Return to Work Action Plan Roles and Responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer-assigned vocational counselor, the SIMP vocational counselor, the attending provider, and the worker are involved. Their specific roles and responsibilities are listed below.

- The SIMP Vocational Counselor:
 - Co-develops the Return to Work Action Plan with the insurer-assigned vocational counselor.
 - Presents the Return to Work Action Plan to the insurer at the completion of the Evaluation Phase if the SIMP recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal.
 - Communicates with the insurer-assigned vocational counselor during the Treatment and Follow Up phases to resolve any problems in implementing the Return to Work Action Plan.
- The insurer-assigned vocational counselor:
 - Co-develops the Return to Work Action Plan with the SIMP vocational counselor.

- Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone.
- Negotiates with the attending provider when the initial Return to Work Action Plan is not approved in order to resolve the attending provider's concerns.
- Obtains the worker's signature on the Return to Work Action Plan.
- Communicates with the SIMP vocational counselor during the treatment and follow up phases to resolve any problems in implementing the Return to Work Action Plan.
- Implements the Return to Work Action Plan following the conclusion of the Treatment Phase.
- The attending provider:
 - Reviews and approves/disapproves the initial Return to Work Action Plan within 15 days of receipt.
 - Reviews and signs the final Return to Work Action Plan at the conclusion of the treatment phase within 15 days of receipt.
 - Communicates with the insurer-assigned vocational counselor during the treatment and follow up phases to resolve any issues affecting the return to work goal.
- The worker:
 - Participates in the selection of a return to work goal.
 - Reviews and signs the final Return to Work Action plan.
 - Will cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan. Should the worker fail to be cooperative, the sanctions as set out in [RCW 51.32.110](#) shall be applied.

Concurrent Treatment

[WAC 296-20-071](#)

It is preferable that an injured worker be under the care of one provider who can treat all areas of injury. However, in some cases, treatment by more than one provider may be allowed.

The insurer can consider allowing concurrent treatment when the accepted conditions resulting from the injury involve more than one body area or system, and/or require specialty or multidisciplinary care.

When requesting consideration for concurrent treatment, the attending provider must provide the insurer with:

- The name, address, discipline, and specialty of all other providers assisting in treatment.
- An outline of their responsibilities.
- An estimate of the length of the period of concurrent care.

Each request for concurrent treatment must be considered on an individual basis. Consideration should be given to all factors in the case, including:

- The availability of providers in the worker's geographic location.
- The AP's willingness to treat all conditions.

Concurrent treatment should be goal-oriented and time-limited. It should rarely be long-term, except in claims with multiple areas of injury, for example:

- Accepted lumbar and mental health conditions.
- Spinal cord injuries.
- Multiple fractures.

When concurrent treatment is allowed, the insurer will recognize one attending provider. The attending provider will be responsible for directing the over-all treatment program, including:

- Monitoring or prescribing medications, when appropriate.
- Providing copies of all reports and other data received from the involved practitioners.
- Providing adequate certification of the injured worker's inability to work in time-loss cases.

Concurrent care providers may prescribe medications, if appropriate. Prescribing concurrent care providers are required to send the AP and the insurer all required reports, including a report of the medications prescribed.

Consultations

[WAC 296-20-051](#)

Medical consultations can be used in claims for a variety of reasons:

- The AP may identify a need for a consultation to evaluate a worker's condition to assist with a diagnosis or treatment plan ([WAC 296-20-051](#)).
- A complete examination is required to determine the need for continued treatment beyond 60 days ([WAC 296-20-035](#)).
- A consultation may be used to determine the appropriateness of drugs a worker is receiving ([WAC 296-20-03015](#)).
- In the event of complication, controversy, or disputes over the treatment aspects of a claim or when conservative care extends past 120 days ([WAC 296-20-045](#)).

Consultations do not require authorization ([WAC 296-20-030](#)) within the guidelines of [WAC 296-20-051](#).

Medical consultants must submit the required reports to the insurer ([WAC 296-20-01002](#) and [WAC 296-20-06101](#)). Any recommendations from the consultant should be sent to the AP to determine if he or she concurs with the recommendations. In some cases, the consultant may recommend treatment which is not within the scope of the AP. If the AP concurs, he or she should assist the worker in selecting a provider who can carry out the recommended treatment. If the AP does not concur with the recommendations, a transfer should not be required.

Coverage Decisions on Medical Devices & Procedures

For coverage decisions made by L&I's Office of the Medical Director, access the [Condition and Treatment Index](#). Select the treatment or condition for additional information about billing and related rules. You will find:

- A list of policies relating to medical devices and procedures.
- Health technology assessments, study reports, and systematic reviews completed or commissioned by L&I.

If you need the department to evaluate a medical device not yet addressed, fill out and submit a [Medical Device Review Request](#) form.

Dental Treatment

[WAC 296-20-110](#)

The insurer is only responsible for repair or replacement of teeth injured or dentures broken as a result of an industrial injury. Dental work needed because of underlying conditions unrelated to the industrial injury, such as decay, is the responsibility of the worker.

Dental repair or replacement may be done by general practitioners or specialists. About 80 percent of all dentists are general practitioners. The following are specialists:

- **Endodontists** deal with the diagnosis and treatment of diseases of the tooth pulp, and injuries involving the pulp and supporting tissues.
- **Oral and maxillofacial surgeons** treat diseases, injuries, and defects of the jaw, mouth, and face using surgery. They also perform extractions.
- **Orthodontists** guide and correct growing or mature dentofacial structure. They also treat conditions that require moving teeth, or correcting malformations or poor relationships of teeth and jaws.
- **Periodontists** treat diseases of the tissues supporting and surrounding the teeth.
- **Prosthodontists** design and fit dentures, bridges, and other replacements for missing teeth.

The dentist must outline the extent of the dental injury and the treatment program necessary to repair damage due to the injury. The insurer must know exactly which teeth were injured.

Dental injuries and their treatment may include:

- **Tooth Fractures** – classified and treated as:
 - **Class I:** Fracture of only the enamel cap of the tooth. Treatment frequently requires only the smoothing of irregularities along the fracture line.
 - **Class II:** Injury extending into the dentin but with no exposure of the pulp. Treatment generally requires restoration of the missing segment, ranging from bonding to full crown restoration.
 - **Class III:** Extensive injury to the crown with a pulp exposure. Treatment generally requires a full crown after cleaning and filling the affected pulp canal.
 - **Class IV:** Fracture at or below the cemento-enamel junction of the tooth. Generally, if the tooth root is fractured apical to the level of cemento-enamel junction, the tooth should be extracted.
- **Luxation** – Simple loosening of a tooth. Treatment may range from simple observation to the need for stabilization or splinting by bonding to adjacent teeth or wiring to existing bridgework or crowns. Direct impact may result in its intrusion (impaction) further into the bone surrounding the socket.
- **Avulsion** – The tooth and root are completely torn away. If brought to the dentist within four to six hours and kept clean and moist, endodontic therapy can be performed extraorally and the tooth replanted and stabilized by bonding to adjacent teeth.

For PPD on dental claims, see the [Permanent Partial Disabilities](#) chapter in the Claims Adjudication Guidelines.

Authorization

All dental work requires preauthorization. Dental work such as extractions, x-rays, caps, crowns, and bridges are payable if needed as a result of the injury. If a bridge or partial denture must be replaced and the abutment or anchor teeth cannot be used, the insurer should authorize extension of the bridge or partial as far as necessary to adequately secure it. When it is necessary to include restoration of previously missing or decayed teeth in order to carry out restorative work needed due to the injury, this can be allowed if the dentist explains and documents the need for the additional work. When it is inadvisable to use any restoration and a full denture is needed due to injury-related loss of teeth, the insurer will pay for the extractions and denture.

Relining of dentures is not authorized in advance or as part of the denture fee. If relining or replacement is needed on a closed claim for dentures provided by the insurer, this can be authorized without reopening the claim. The insurer is unable to authorize further dental work unless the claim is reopened.

Although dental implants are no longer considered experimental or controversial, they are more expensive than alternate treatments, such as bridges or partial dentures. If dental implants are requested, the insurer should find out why implants are considered the appropriate treatment and obtain justification of why other dental procedures would not be acceptable. If the reason for implants over other alternatives is cosmetic, or the worker prefers them to another medically acceptable alternative, the request will likely be denied. If the reason for implants is that they are the best treatment alternative, they should be covered. For example, if a worker has healthy teeth and gums but has lost front teeth, implants may be the appropriate treatment.

General Drug Guidelines

General Principles Used to Determine Coverage

[WAC 296-20-03010](#)

The insurer will pay for no more than a 30-day supply of a drug at any one time (except in pension cases or claims held open for life-sustaining treatment). See [WAC 296-20-01002](#) for the definition of proper and necessary.

The insurer pays for drugs when they are used as recommended by the FDA, or within current medical standards.

General Limitations

[WAC 296-20-03011](#)

- Payment is made for a 30-day supply at a time, including opioids and other scheduled drugs.

- Payment is made for over-the-counter items when prescribed by the provider.
- Prescriptions must be filled with generic drugs unless the provider indicates a substitution isn't permitted.
- Payment isn't made for scheduled drugs for continuing pain on pension claims.
- Payment is made for unrelated drugs only when hindering recovery. Prior authorization is required.

Outpatient Drug and Medication Decisions

[WAC 296-20-03012](#)

The department's complete formulary can be found on the department's <https://lni.wa.gov/patient-care/treating-patients/drugs-and-prescriptions/>

The formulary lists drugs in the following categories:

- Allowed: Drugs routinely used for treatment of accepted industrial injuries and occupational diseases.
- Prior authorization required: Some drugs require prior authorization usually because they are for conditions not normally considered work-related.

Example: Drugs to treat hypertension.

- Denied: Drugs not normally used for treating industrial injuries or not normally dispensed by outpatient pharmacies.

Example: Hormones and most nutritional supplements.

Drugs with Limitations

[WAC 296-20-03014](#)

- Injectable drugs are covered for inpatients during emergency treatment or in cases of severe injuries when needed for dressing or cast changes.
- In general, injectable drugs are not covered for outpatients. For post-operative care, injectable drugs may be covered for 48 hours from the time of discharge.
- Insulin, heparin, anti-migraine medications, or drugs for impotency treatment are covered only when proper and necessary.
- Sedatives or hypnotics are not covered for chronic conditions.

- Benzodiazepines (**Examples:** Valium, Ativan, Serax, Klonopin, Dalmane) are covered only for:
 - Inpatients.
 - Workers with accepted mental health conditions.
 - A mental health condition retarding recovery.
 - Workers with spinal cord injuries.
 - Cancer.

(**Hint:** Look for drugs ending in “zepam”)
- Stadol, a nasally-administered pain reliever, is not covered.

Special Drug Situations

- See [WAC 296-20-03013](#) for special circumstances for payment of denied outpatient drugs.
- See [WAC 296-20-03015](#) for the steps to take if there are concerns with medications prescribed for the worker.
- See [WAC 296-20-03085](#) for rules regarding payment for detoxification or chemical dependency treatment.
- See [WAC 296-20-03017](#) for reporting requirements for prescribing providers.
- See [WAC 296-20-03018](#) for payment of inpatient drugs.
- [WAC 296-20-03030 through WAC 296-20-03085](#) covers opioids for **non-cancer** pain.
- For rules regarding payment for opioid medications for treatment of chronic pain, see the department’s Opioid Guidelines.

Hearing Aids and Masking Devices

[WAC 296-20-1101](#)

If a worker’s hearing aids are damaged or lost due to an industrial accident, the insurer is responsible for repair or replacement of the device, only to the extent of restoring the damaged item to its condition at the time of the accident. If the device is repairable and the worker prefers a replacement, the insurer is only responsible for what it would cost to repair to the device. The worker is then responsible for any additional cost for the replacement.

If hearing loss is an accepted industrial condition, either due to an injury or an occupational exposure, the insurer must cover the cost of hearing aids when prescribed or recommended by a physician. Once a hearing aid has been provided, the insurer is responsible for:

- Repairs due to normal wear;
- Replacement due to normal wear;
- Replacement upon request five years after the issue date of the current hearing aid; and
- Battery replacement for the life of the hearing aid.

When tinnitus has been accepted on a claim, masking devices may be covered by the insurer under the same provisions as hearing aids.

Hearing aids and masking devices require prior authorization ([WAC 296-20-03001](#)). This authorization must be communicated in writing as outlined in [WAC 295-15-425](#).

Home Health and Nursing Home Services

Introduction

Home health care providers, such as registered nurses (RNs), physical therapists (PTs), occupational therapists (OTs), speech therapists (STs), attendants, nursing homes, hospices, and other residential care services require prior authorization. Self-insurers must provide written authorization or denial as outlined in [WAC 296-15-425](#).

The insurer will only pay for proper and necessary care and the supplies needed because of the physical restrictions caused by the industrial injury or occupational disease. The insurer will not pay for services that are not specifically authorized.

Home Health Care and Attendant Services

[RCW 51.32.060](#)(3), [RCW 51.32.072](#), [WAC 296-20-091](#), [WAC 296-23-245](#), [WAC 296-23-246](#)

In order to receive home health care or attendant services, the worker must be physically unable to care for his or her personal needs. In addition, the attending provider must advise that these services are necessary due to the industrial injury or occupational disease.

Home health care and attendant services will be provided in the worker's residence. These services allow the worker to stay at home instead of in a hospital or skilled nursing facility.

Home Health Care Definitions

[WAC 296-20-01002](#)

The following terms are commonly associated with home health care and attendant services:

Agency – One of three types: home health, home care, or hospice. The Department of Health licensing law describes the types of services each can provide. L&I requires that agencies be licensed.

- Home Health Care Agency – Provides personal care services, and supplies multiple services in the home, such as PT, OT, ST, and nursing care.
- Home Care Agency – Provides personal care services, such as feeding, dressing, and bathing, but not nursing care. This type of agency can be used for long-term maintenance attendant services.
- Hospice Agency – Provides care to workers with terminal illnesses where death is imminent.

Home Health Care – A professional service provided by RNs, PTs, OTs, or STs, or aide care supervised by health care professionals. Home health care includes hourly and intermittent nursing care that is medically necessary and coordinated by a nursing agency. It may be long- or short-term, depending on the needs of the worker. For example, a worker in a body cast may need temporary care, and a quadriplegic may need permanent care.

Approved hours will be based on an RN's home nursing evaluation of the worker's care needs. A written report must be submitted to the insurer within 15 days of the evaluation. Updated plans must be submitted every 30 days thereafter. Respite (interval of rest or relief) care must also be approved in advance. Some examples of home care services include:

- Home PT and OT for workers to be taught ambulation, transferring, or other activities of daily living in their home environment.
- Home professional nursing care for home IV antibiotic administration, sterile dressing changes, or oxygen administration.
- Home health aide care for bathing, dressing, toileting, feeding, and to follow some health care treatment plans, such as range of motion (ROM) exercises or skin inspection for pressure sores.

Attendant Services – Proper and necessary personal care services provided to maintain the worker in his or her residence. Workers who are temporarily or permanently totally disabled and unable to care for themselves because of their industrial injuries or occupational diseases may receive attendant services.

Attendant services must be requested by the AP and authorized by the insurer before the care begins. The insurer will determine the maximum hours of authorized attendant services, based on an RN's home nursing evaluation of the worker's care needs. If the worker's care needs change, the worker or provider may request a new evaluation.

All attendant services must be provided through a home health or home care agency. In order for spouses to provide attendant care, they must be employed by an agency.

Exception: Spouses who provided attendant care to injured workers prior to October 1, 2001, and who meet department criteria, may continue to provide attendant care. The insurer does not authorize *new* requests for spouses not employed by an agency to provide attendant care.

Spouses eligible to provide attendant care are limited to a maximum of 70 hours per week or to the maximum hours authorized for the worker, whichever is less. If more than 70 hours of care per week are medically necessary, a second provider may be approved. The second provider must be employed by an agency eligible to provide attendant services.

Respite care will be allowed when non-agency spouse caregivers are unable to provide care due to their own illnesses, injuries, etc. Respite care must be authorized by the insurer and must be provided by licensed agencies.

The following are examples of attendant services that may be covered:

- Bathing and personal hygiene
- Dressing
- Administration of medications
- Specialized skin care, including changing or caring for dressings or ostomies
- Tube feeding
- Feeding assistance (not meal preparation)
- Mobility assistance, including walking, toileting, and other transfers
- Turning and positioning
- Bowel and incontinence care
- Assistance with basic ROM exercises

No additional compensation is made for travel, mileage, holidays and weekends, overtime, shift differentials, or supervisory visits. These expenses are considered part of the fee paid to the home health or home care agency.

Homemaker or Chore Worker Services – Required to meet the worker’s everyday environmental needs. These services are considered unrelated to the medical care of the worker and are not covered. The following are examples of services that are not covered:

- Housecleaning
- Laundry
- Shopping
- Meal planning and preparation
- Transporting the worker
- Errands
- Recreational activities
- Yard work
- Child care

However, the insurer may consider payment for chore services during hospice care.

Nursing Home, Residential, and Hospice Care Services

Workers should be discharged from the hospital at the earliest date possible, consistent with proper health care ([WAC 296-20-075\(2\)](#)).

When a worker continues to need help with care but no longer needs hospitalization, special nursing care, home nursing services, attendant services, or transfer to a nursing home or convalescent center can be authorized. This could apply to workers who are ambulatory in a restricted way and who no longer require acute care. If transfer to a nursing home or convalescent center is indicated, the AP should make prior arrangements with the insurer.

Residential care services require prior authorization. Services must be proper and necessary, required due to an industrial injury or occupational disease, and requested by the attending provider.

Residential care facilities include:

- Skilled Nursing Facilities
- Nursing Homes

- Transitional Care Units
- Critical Access Hospitals
- Adult Family Homes/Boarding Homes, including:
 - Assisted Living Facilities
 - Adult Residential Care
 - Enhanced Adult Residential Care
- Hospice care providers

Services in adult day care centers are **not covered**.

Independent Medical Examinations

[RCW 51.32.110](#), [RCW 51.36.070](#), Policy 13.05, Policy 13.07

An independent medical examination (IME) is defined in [WAC 296-23-302](#) as “an objective medical-legal examination requested (by the department or self-insurer) to establish medical facts about a worker’s physical condition.” An IME can only be scheduled for the following reasons:

- To make a claim allowance decision
- To make a claim reopening decision
- To resolve a new medical issue
- To evaluate treatment progress
- To evaluate a worker’s Permanent disability
- To establish a worker’s work restriction
- To resolve an appeal

Consider using an approved provider consultation instead of an IME as it may be more cost effective while still accomplishing the same goal. Complete medical records and a clear purpose statement of the examination request will result in a well-documented, unbiased opinion.

A copy of the report must be sent to the attending physician and the injured worker in accordance with Policy 13.05.

A worker may bring an adult friend or family member to an IME for comfort and reassurance, but there are restrictions under [WAC 296-23-362](#) for the accompanying person.

Scheduling Independent Medical Examinations

[RCW 51.36.070](#), [RCW 51.32.114](#), [RCW 51.32.110](#), [WAC 296-14-410](#)

IMEs and consultations must be scheduled with department-approved examiners. In setting up the examination, the self-insurer must have complied with the following:

- Scheduled at a time and place reasonably convenient for the worker or alternatively utilize telemedicine if the department determines telemedicine is appropriate.
- L&I developed the [Reasonably Convenient Location](#) (RCL) tool to help self-insured employers identify where residents in the worker's community likely travel for care to various medical specialties (RCW 51.36.070). These locations are determined by:
 - The number of providers in each county participating in the Medical Providers Network (MPN).
 - The closest driving distance between the starting location and each county seat.

NOTE: "Reasonably convenient" is defined as "a place where residents in the injured worker's community would normally travel to seek medical care for the same specialty as the examiner." Local options and telemedicine must be exhausted before requiring the worker to travel,

- Given the worker written notice, at least 14 days but not more than 60 days, prior to the exam. If the worker has had legal representation, send one notice directly to the worker and one copy to their representative.
- Provided the date, time and directions to the location of the medical examination.

Compensation for Attending an Independent Medical Examination

[RCW 51.32.110](#)

Workers must be paid their usual wages when they miss work to attend an independent medical exam (IME) at the request of the department or self-insurer. They should be compensated in one-hour increments for actual work hours missed to attend an examination. This rule does not apply to workers who have not returned to work and are receiving time-loss compensation; they would be paid time-loss.

Workers are entitled to be compensated for mileage to and from the IME, regardless of the distance traveled.

See Travel Expenses in the [Miscellaneous Claim Issues](#) chapter for other reimbursements.

No-Show Fees

In accordance with [RCW 51.32.110](#), if the worker gives at least five business days' notice of the intent to not attend the examination, a no-show fee may not be assessed and the IME rescheduled if appropriate.

For more information on No-Show Fees for an IME, see the [Miscellaneous Claim Issues](#) chapter.

Infectious Diseases

When a disease can be readily transmitted from one individual to another, it is called communicable or infectious. Examples of infectious diseases are hepatitis A, hepatitis B, influenza, rabies, tetanus, meningitis, tuberculosis, and acquired immunodeficiency syndrome (AIDS). Validity issues regarding infectious disease claims are discussed under Filing an Infectious Disease Claim in the [Claim Validity](#) chapter.

Preventative Treatment

Payment for testing, inoculation or immunological treatment may be authorized when a **work-related** activity has resulted in probable exposure to a potential infectious occupational disease. This should be authorized even if the disease has not been contracted and there is no allowable claim. Routine inoculations without a specific incident of exposure are not payable.

L&I guidelines for the management of possible exposures to hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV) can be found on the department website under [Post Exposure Prophylaxis and Testing](#).

Confidentiality of Infectious Disease Records

Claims for hepatitis A, B, and C, human immunodeficiency virus (HIV), AIDS, and other diseases that may be sexually transmitted (STDs) are confidential claims and must be handled with special care. Policy 1.42 defines STD as “a bacterial, viral, fungal, or parasitic disease or condition usually transmitted through sexual contact.” Examples include, but are not limited to, gonorrhea, nongonoccal urethritis, and syphilis. Whether the disease was transmitted sexually or by some other means does not affect its confidential status.

As specified in Policy 1.42, individuals or groups not authorized to handle or determine medical claim payments must obtain an STD release from the worker to receive STD information. This means that some parties who can receive claim information on a claim without STD information cannot receive any STD information without the STD release signed by the worker. Examples include the worker's attorney, chiropractors (even when they are the attending provider), and ancillary health care providers.

Injections (Therapeutic or Diagnostic)

Epidural Injection

An epidural injection is the injection of an anesthetic or steroid given on or outside the dura (the first layer of the meninges or spinal covering). It can be used therapeutically or diagnostically and is safely administered in an outpatient setting in most situations.

Epidural injections are used to treat the swelling, pain, and inflammation of radiculopathy where there are signs and symptoms that normally suggest entrapment of a specific spinal nerve root.

Note: Low back pain alone is not sufficient for authorization.

Prior authorization is required. The self-insurer must communicate in writing the treatment authorization or denial as outlined in [WAC 296-15-425](#). A maximum of six injections per acute episode may be allowed, but no more than three injections in a 30-day treatment period. The treatment period must be followed by a 30-day evaluation period. An additional series of three injections will be allowed if there is significant relief from the first series of three injections. (See [WAC 296-20-03001\(7\)](#).)

Vertebral Facet Joint Injection

Effective October 1, 2014, vertebral facet injections are no longer payable per the [Spinal Injections coverage decision](#). However, medial branch nerve blocks can still be used on a diagnostic basis to determine whether a worker is a candidate for a facet neurotomy.

Trigger Point Injection

A trigger point injection is an injection of an anesthetic or steroid into a tender area of muscle, fascia, ligament, or tendon. It is used to treat localized pain in the area being injected. Trigger point injections are safely administered in an outpatient setting.

The first series of three injections does not require authorization. The second series of three injections requires justification and the procedure code from the attending provider. A maximum of six injections may be allowed for any claim. Because each new claim is a new event, and since the purpose of the injections is to decrease inflammation, a new series of injections may be appropriate for each new claim.

Note: If both trigger point and dry needling injections are provided, a maximum of six injections of both may be allowed under any claim.

Dry Needling Injection

Dry needling is considered a variant of trigger point injections only without medications. It is a technique where needles are inserted directly into trigger point locations, but no medications are injected. This is different than acupuncture; in acupuncture, needles are inserted in the distant points or meridians (pathways of energy, a term used in acupuncture).

Dry needling follows the same rules as trigger point injections and is included in the maximum of six of any combination of trigger point and dry needling injections allowed per claim. (See [WAC 296-20-03001](#).)

Hyaluronic Acid Injection

Hyaluronic acid, a complex sugar chain substance with viscous properties, has been approved as a device for the treatment of osteoarthritis of the knee by the Food and Drug Administration (FDA). The device is marketed under the trade names Hyalgan, Synvisc, and Supartz. (See [Hyaluronic Acid/Viscosupplementation](#) on L&I's website.)

Cartilage in the knee normally provides a cushion between the bones to allow the joint to move smoothly. Hyaluronic acid is naturally produced by the body and lubricates cartilage within the joint. However, osteoarthritis can cause the cartilage and other structures of the joint begin to break down. In some workers, a small amount of inflammation breaks down the hyaluronic acid so that lubrication is lost, joints become stiff and movement is painful. Hyaluronic acid injections replace or supplement the body's natural hyaluronic acid that is broken down by inflammation. Hyaluronic acid is indicated for the treatment of knee pain caused by osteoarthritis only under the following conditions:

- Worker has a documented contraindication for other forms of non-surgical care, including NSAIDS, corticosteroid injections, and physical therapy.
- Limited to two courses of treatment per year with at least four months between courses.
- Documented evidence of clinical benefit in terms of pain and function from the prior course of treatment is required for subsequent treatment.

Though pain relief for 6 to 12 months is the primary purpose of this therapy, a secondary goal is to delay or prevent a total knee replacement. Hyaluronic acid injections are indicated only for osteoarthritis of the knee. Other uses are considered experimental, and therefore, are not payable. (See [WAC 296-20-03002](#)(6).)

Hyaluronic acid is administered by intra-articular injection on an outpatient basis. The schedule of injections varies with the FDA-approved product used. One course of the currently approved products consists of one of the following:

- Hyalgan or Supartz, administered by intra-articular injection once a week (one week apart), for a total of five injections.
- Synvisc or Orthovisc, administered by intra-articular injections once a week (one week apart), for a total of three injections.

The use of hyaluronic acid is covered when osteoarthritis is an accepted condition. It is not payable as temporary treatment if osteoarthritis is an unrelated condition. The self-insurer must communicate in writing the treatment authorization or denial as outlined in [WAC 296-15-425](#).

One course of hyaluronic acid may be considered medically necessary when osteoarthritis of the knee is a diagnosed and accepted condition. The requesting provider must provide the insurer with documentation of the existence of osteoarthritis of the knee, and with documentation that the worker has failed to benefit from, or is unable to tolerate, all of the following therapies recommended by the American College of Rheumatology:

- **Non-pharmacological** therapies, e.g., PT.
- Non-opioid analgesics, e.g., acetaminophen.
- Treatment with non-steroidal anti-inflammatory drugs (NSAIDs). Intolerance, e.g., rash, gastropathy, etc., and therapeutic failure must be documented with at least a one-week trial of two formulary products from different NSAIDs classes.

Additional course of hyaluronic acid treatment. Under rare circumstances, an additional course of hyaluronic acid treatment may be considered. In order for additional courses of hyaluronic acid injections to be considered medically necessary:

- The provider must request prior authorization in writing.
- The request must include documentation of the return of pain complaints and the evidence of functional improvement for a worker who has undergone a prior course of hyaluronic acid treatment.

Chymopapain Injection

Chymopapain injection is also known as chemonucleolysis. Chymopapain injections may be authorized for the treatment of lumbar disc disease under certain limitations and criteria according to [WAC 296-20-03004](#). This procedure involves the injection of chymopapain (an enzyme derivative of papaya) into the vertebral column to disintegrate ruptured disc material.

Prior authorization is required, and the procedure should only be authorized once per worker. Authorization should not be granted if the worker has had prior lumbar surgery at the level to be injected. Authorization or denial must be communicated in writing as outlined in [WAC 296-15-425](#).

Botulinum Toxin-A Injection (Botox)

Botulinum toxins (BTX) prevent synaptic transmission of acetylcholine resulting in muscle paralysis. They may also inhibit afferent neurotransmitters and sensory pathways. The most well-known type of injection is onabotulinumtoxinA, or Botox[®]. Chronic migraines are one of the most common conditions for which Botox injections may be recommended.

Botulinum toxin injections require prior authorization, which must be communicated in writing as outlined in [WAC 296-15-425](#). Coverage of these injections is limited to FDA-approved

indications, with the exception of cerviobrachial syndrome. No more than two courses of injections may be authorized under a claim. The second course must be done at least 90 days after the first and only if the first course provided a meaningful, functional response.

Exception: Catastrophic injuries, such as spinal cord injuries, are exempt from the two-course limit and requirement of meaningful improvement in function. In these cases, up to four courses of injections may be authorized per year.

See the department's [coverage decision](#) online for more information and specific coverage criteria.

Injectables

Per [WAC 296-20-03002](#)(2), the insurer will not authorize or pay for injections of:

- Colchicine (a medication given for gout, a joint disease which is not work-related).
- Fibrosing or sclerosing agents, unless they are used for chemotherapy for an accepted condition or for a condition that is retarding recovery.
- Injections of substances other than anesthetic or contrast into the subarachnoid space (intrathecal injections).

If a request is received for these injections, the self-insurer must deny the requested treatment in writing as outlined in [WAC 296-15-425](#).

In addition, prescriptions for home use of injectable drugs are generally not covered. (See [WAC 296-20-03014](#).) These include:

- Narcotics
- Sedatives
- Analgesics
- Antihistamines
- Tranquilizers
- Psychotropics
- Vitamins
- Minerals
- Food supplements

- Hormones

The insurer covers injectable medications under the following circumstances:

- For inpatients, except when the hospital admission is solely for the administration of drugs to relieve chronic pain.
- During emergency treatment of a life-threatening condition or injury.
- During outpatient treatment of burns or fractures when needed for dressing or cast changes.
- During the preoperative and post-operative periods, not to exceed 48 hours from the time of discharge.
- For prescriptions of injectable insulin and heparin and prescriptions for syringes and needles specifically for use with insulin and heparin. Normally, prescriptions for syringes and needles are prohibited.
- For injections of vitamins for specific therapeutic treatment of the accepted condition when the provider can demonstrate that published clinical studies indicate vitamin therapy is the treatment of choice for the condition.

Medical Exams Requested by Self-Insurer

[RCW 51.32.110](#)

Workers must be paid their usual wages when they miss work to attend an exam at the request of the self-insurer. They should be compensated in one-hour increments for actual work hours missed to attend an examination. This rule does not apply to workers who have not returned to work and are receiving time-loss compensation; they would be paid time-loss. Workers are entitled to be compensated for mileage to and from the exam, regardless of the distance traveled. See Travel Expenses in the [Miscellaneous Claim Issues](#) chapter for other reimbursements.

Medical Reports and Documentation

In order to make accurate and timely decisions when adjudicating a claim, the insurer must have current, complete medical information on the worker's condition and treatment needs. The insurer is not a medical expert and must rely on medical providers for that expertise.

The insurer is responsible for ensuring that adequate medical reports are on file to adjudicate the claim and to support their authorization decisions on treatment, time-loss compensation benefits, and other claim benefits. If these documents are not in the file or file documents are incomplete, the insurer must obtain whatever information is needed to complete the claim file.

Reporting Requirements

Providers are required to submit reports at various times during the course of a claim. [WAC 296-20-06101](#) lists the required reports, the specific timeframes within which the provider must submit them, and the information that should be contained in them.

- **Provider's Initial Report (PIR).** This is the first report required of the provider. The provider helps the worker fill out the PIR and is expected to submit it to the insurer within five days of the worker's visit.
- Doctors licensed to practice medicine and surgery (MD), osteopathic medicine and surgery (OD), chiropractic (DC), naturopathic (ND), podiatry (DPM), dentistry (DDS or DMD), or optometry (OD), advanced registered nurse practitioners (ARNPs), and certified physician's assistants (PA-Cs), may sign and be paid for completion of this form.
- **60-day narrative report.** When conservative (non-surgical) treatment continues beyond 60 days, the AP must submit a narrative report every 60 days to support and document the need for continued care.
- If the worker requires treatment beyond 60 days following the injury, the claim most likely involves a major industrial condition or a complication by another condition. In these situations, a complete examination is necessary to determine whether the insurer needs to authorize continued treatment and pay time-loss compensation benefits. This examination may either be done by the AP or by a consulting provider. The examiner must submit a detailed examination report to the insurer. (See [WAC 296-20-01002](#) and [WAC 296-20-035](#) for more information.)
- The only exception to this 60-day reporting requirement is for a claim for severe or extensive injuries, such as quadriplegia, paraplegia, or multiple fractures. Due to the complexity of injuries such as these, there is usually an abundance of medical reports supporting treatment and time-loss compensation benefits.
- **Office notes.** Office notes may also be referred to as chart notes or progress notes. They must be sent following each office visit. Providers may submit legible comprehensive office/chart notes in lieu of 60-day narrative reports if the notes include all the information required in the 60-day narrative report. However, office notes are not acceptable in lieu of specifically requested reports (special reports), and the provider may not bill the special report fee for office notes submitted in place of a requested special report.
- **Special report/follow-up report.** Special reports are used to respond to specific questions asked by the insurer or vocational counselor (VRC), and are payable only when requested by the insurer.

- **Consultation examination report.** Following 120 days of conservative (non-surgical) care, a consultation with another provider is required to obtain an objective evaluation of the need for ongoing conservative medical management. (See [WAC 296-20-01002](#) for the definition of consultation examination report, [WAC 296-20-045](#) for other times consultations are required, and [WAC 296-20-051](#) for consultation rules.) If the worker has been seen by the consulting provider within the past three years, the consultation will be considered a follow-up office visit. Therefore, instead of sending a consultation report, the provider should submit a follow-up (SOAPER) report and bill accordingly. (See [WAC 296-20-06101](#).) A copy of the consultation or follow-up report must be submitted to the AP, and must be received by the insurer within 15 days of the date of the consultation.
- **Attending provider review of IME report.** This review is to obtain the AP's opinion about the accuracy of the diagnoses and information provided in an IME. The AP should include his or her agreement or disagreement with IME findings and recommendations. If the AP disagrees with the IME, he or she should provide objective and subjective findings to support the opinion, along with his or her further treatment plans.
- **Reopening application.** On claims closed over 60 days, the insurer will pay for the completion of a [reopening application](#), an office visit, and diagnostic studies necessary to complete the application. No other medical benefits will be paid until the claim manager makes a decision on the reopening.
- **Ancillary provider reports.** While it is important to have current medical reports to support treatment provided by the worker's doctors, it is also important to have current medical reports from other types of providers, such as lab, radiology, and physical therapy. [WAC 296-20-06101](#) lists the provider type and whether chart notes, reports, or both are required. In addition to the requirements in [WAC 296-20-06101](#), [WAC 296-20-125](#) requires ancillary providers to submit supporting documentation when billing for services.
- **Activity Prescription Form (APF).** Providers may complete Activity Prescription Forms (APFs) to communicate the worker's ability to work, functional capacities, physical restrictions, and/or treatment plan. APFs are payable only when all required sections of the form are complete and legible. Providers may submit up to six APFs per worker within the first 60 days of the initial visit, and then up to four times per 60 days thereafter. Detailed information regarding appropriate use and billing for Activity Prescription Forms is available on the department's [web site](#).

When the AP Does Not Cooperate

[WAC 296-20-065](#)

If the AP does not respond to requests for medical information, the insurer should write to the provider regarding reporting requirements. The provider should be advised that authorization and payment of further treatment is contingent on receiving the required medical reports.

If the AP fails to cooperate, the self-insurer may require the worker to select another provider for treatment.

Report Content – SOAPER

In addition to the requirements in [WAC 296-20-01002](#) and [WAC 296-20-06101](#), the department has asked providers to provide office/chart/progress notes and 60-day narrative reports using the “SOAPER” format. SOAPER contents include:

- S** – The worker’s **subjective** complaints or symptoms about the injury or incident reported by the worker, employer, co-worker, family member, or friend. Subjective complaints are what the worker senses or feels; they cannot be measured or independently proven.
- O** – The provider’s **objective** findings are independent of voluntary action and are all the findings the examiner can see, feel, or consistently measure. This includes factual information, such as physical exams, range of motion (ROM), muscle spasms, lab tests, x-rays, and psychological testing.

The objective findings should be consistent and logical. The provider should identify the significant objective basis that supports his or her medical opinion regarding a diagnosis, the need for treatment, or the worker’s inability to work.

- A** – The provider’s **assessment** of progress toward meeting goals is the conclusion the provider makes after evaluating all the subjective complaints and objective findings. The conclusion may be:

- A definite diagnosis (dx.).
- A rule out (R/O) diagnosis – suspected diagnosis.
- An etiology (ET) – origin of the diagnosis.
- A prognosis – prediction of the probable course of, or the likely recovery from, the disease or injury.
- Maximum medical improvement (MMI) – the point when no fundamental or marked change in an accepted condition can be expected, with or without further treatment. MMI is the term most often used by medical providers.

MMI is also referred to as “fixed and stable.” However, fixed and stable is a department term and is generally not used by medical professionals. A condition is considered to be at MMI or fixed and stable when it is reasonably certain that further medical treatment will not predictably alter the course of the illness or medical condition. (See [RCW 51.36.010](#) and [WAC 296-20-01002](#) for the definition of proper and necessary.)

Even if a worker has reached MMI, there may be fluctuations in levels of pain and function, and the condition might be expected to either improve or deteriorate with the passage of time. When a worker's condition reaches this point, treatment that results in only temporary or transient changes is not consider proper and necessary.

- Probability, if any, of permanent partial disability (PPD) resulting from the industrial condition.

P – The provider's treatment **plan**. What the provider recommends based on the assessment. The plan should include a goal (the expected outcome), the prescribed treatment (specific modalities and frequency), and the length of the treatment plan (expected completion date and anticipated outcome). The treatment plan should include information on the worker's functional improvement. Providers are also requested to mention any risk factors for **chronic** disability in this area of the report.

E – **Employment** issues. The provider should provide the following types of information about the worker's employment status:

- Whether the worker is currently working, and if so, at what job.
- Whether the worker been released for work, if not currently working.
- When the provider anticipates releasing the worker for work.

R – **Restrictions** to recovery. The provider should list any restrictions, barriers, or unrelated conditions preventing recovery or return to work. If the worker has not returned to work, the provider should include an estimate of physical capacities and should:

- Describe the physical limitations, both temporary and permanent, that keep the worker from returning to work.
- Indicate whether the worker can perform modified work or different duties while recovering.
- Indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work, and if so, why.

Reviewing Medical Reports

When reviewing medical reports, the following questions should be asked:

- Does the provider clearly report subjective and objective information, assessment, and plan (SOAP)?
- Are there objective findings to substantiate the subjective complaints?

- If the worker has not returned to work, has the provider addressed employment issues and restrictions to recovery?
- Does the provider state that the injury or illness is directly related to the worker's employment?
- Is there a stated, measurable treatment goal with a reasonable, expected completion date?
- Does the provider include a prognosis with the diagnosis?

Components of a Medical Chart

A medical "chart" or "record" is a comprehensive file kept by health care providers on the individuals they treat. It can be brief or lengthy depending on how much care the person has received. Some examples of what may be put in a medical chart are:

- History and physical report – The initial part of a chart. The patient's personal and family medical history and the initial examination.
- Progress notes and reports
- Operative reports
- Consultation reports
- Ancillary provider reports – Reports from other types of providers such as lab, radiology, and physical therapy.

Employer Requests for Return to Work Information

Studies have shown that workers recover more quickly when they return to work as soon as possible following an injury. Employers are encouraged to offer light duty, modified work, or transitional work to their injured workers.

If the AP's chart notes, reports, or APFs do not contain the current medical information necessary to assist their workers in returning to work, the employer may request current physical capacity information from the AP.

Obtaining Prior Medical Records

Prior medical records may be needed at any point in a claim. For example, when:

- The worker had prior treatment to an area of the body affected by the accepted injury.

- An unrelated condition is retarding recovery from the accepted condition, e.g., prior to the injury, the worker had been treated for depression and that is now impacting recovery.

The presence of a preexisting condition does not disqualify a worker from receiving benefits, but it may affect the extent of benefits available under the current claim(s). Therefore, the insurer must establish as soundly as possible the existence of any prior condition.

The insurer should request copies of prior treatment records from the worker and the worker's providers. The prior records will give a better understanding of what the worker's condition was at the time of the current injury.

When an injured worker signs the SIF-2/PIR, they are also signing a medical authorization permitting medical care providers to release, without liability, the worker's pertinent medical records to the insurer ([RCW 51.36.060](#)). To obtain medical records, the insurer may forward to the provider a copy of the signed SIF-2/PIR with a letter requesting needed medical records.

If a provider questions the release for records because of the federal Health Information Portability and Accountability Act (HIPAA), the insurer may send the provider a copy of the department's [Release of Medical Records and Patient Privacy in Workers' Compensation](#) document.

Detailed information about HIPAA can be found at the web site for the [U.S. Department of Health and Human Services](#).

Newly Contended or Unrelated Medical Conditions

Contention of a New Condition

When a new medical condition arises in an existing allowed claim, the worker or medical provider may believe the new condition is a result of the industrial injury and may request medical and/or disability benefits for the new condition under the existing claim.

Contention may be **obvious**: the worker or medical provider contacts the insurer and requests treatment for a new condition.

Contention may also be **less obvious**, with a new condition showing up in:

- Progress or chart notes.
- Medical bills with unrelated diagnostic or procedure codes.

- Physical therapy notes.
- A new medical provider's reports and bills (e.g. a chiropractic bill listing back conditions on a claim for a knee condition).
- Diagnostic test results.

Conditions Resulting from Treatment for the Industrial Injury or Occupational Disease

A condition arising from treatment rendered for an industrial injury or occupational disease should be accepted on a claim, provided the condition is diagnosed and related to the claim by a medical provider. For example:

- A worker has a knee injury which requires the use of crutches. From using the crutches, the worker sustains a shoulder strain. Since the use of the crutches for an allowed condition caused the shoulder strain (regardless of whether the worker used the crutches correctly, they were the wrong size, etc.) the shoulder strain should be accepted under the claim. The same would be true if an accepted knee condition caused a worker to fall, injuring another part of the body such as an arm.
- Deep vein thrombosis (DVT), a blood clot that develops in a deep vein, may occur following a surgery, traumatic injury, or prolonged hospitalization. DVT may cause pain and can lead to complications if the clot breaks off and travels in the blood stream to the lungs.
- Surgical complications.
- Reactions to medication.

Segregation of an Unrelated Condition

If information is received regarding an obviously unrelated condition that is not affecting recovery, and **not contended** by anyone to be related to the industrial injury or occupational disease, the insurer may send a letter notifying all concerned that the condition is not covered under the claim.

If the worker or provider **is contending** that a new condition is related to the industrial injury or occupational disease, the insurer will need to decide whether they believe it should be accepted on the claim. Several factors to consider include:

- The description of the initial injury. Is it reasonable that at the time of the injury the worker also injured the newly contended body part?
- The length of time between the date of injury and the onset of symptoms related to the additional condition.

- Prior medical records for the new condition. Did the worker receive treatment for the condition prior to the injury?
- A medical opinion giving a causal relationship regarding whether a contended condition is related to the covered injury on a more probable than not basis.

Within five days of determining whether or not the condition should be accepted under the claim, the worker must be notified with the appropriate template, as required by [WAC 296-15-425](#):

- [Accept Newly Contended Condition](#) (form F207-220-000), or
- [Deny Newly Contended Condition](#) (form F207-221-000).

These templates advise the worker to call the insurer with questions and that he or she has the right to dispute the decision to the department if there is a disagreement. If a dispute is received, the department adjudicator will review the file and issue an order directing the self-insurer to either accept or deny the condition.

If no dispute is received, the department will not issue an order regarding acceptance or denial of new conditions under a claim.

Temporary Treatment of Conditions Delaying Recovery

[WAC 296-20-055](#), [WAC 296-20-081](#)

Conditions not related to the industrial injury or occupational disease are not the responsibility of the insurer.

When an unrelated condition is being treated concurrently with the injury, the attending provider must notify the insurer immediately and submit the following:

- Diagnosis and/or nature of unrelated condition.
- Treatment being rendered.
- The effect, if any, on the industrial condition.

Authorizing Temporary Treatment

[WAC 296-20-055](#), [WAC 296-20-03013](#)

When an unrelated condition is delaying recovery of the accepted condition(s), temporary treatment can be covered with prior approval of the insurer. The request for approval should include a thorough explanation of how the unrelated condition is affecting the industrial condition.

When authorizing temporary treatment covered under [WAC 296-20-03001](#), the insurer must notify the worker in writing using the [Treatment Decision](#) template ([WAC 296-15-425](#)). In the free text section of the template, inform the worker that the treatment is authorized on a temporary basis only, and explain why.

Obesity Treatment Programs

Obesity does not meet the definition of an industrial injury or occupational disease. Weight loss services may be allowed on a temporary basis when an unrelated obesity condition impedes recovery from an accepted condition ([WAC 296-20-055](#)). Services for weight loss treatment **require prior authorization** ([WAC 296-20-03001](#)). The attending provider must submit medical justification including tests, consultations, or diagnostic studies that support the request. After review of the request the self-insurer must communicate in writing the treatment authorization or denial as outlined in [WAC 296-15-425](#).

To be eligible for weight loss treatment, the worker must be severely obese. Severe obesity for the purposes of providing weight loss treatment is defined by the department as a Body Mass Index (BMI) of 35 or greater. For example, a person 5 feet 5 inches tall, weighing 210 or more pounds is considered severely obese.

The following table from [MedicineNet.com](#) has already calculated the BMI and converted the result to inches and pounds. To use the table, find the height in the left column and the weight in the same row. The number at the top of the column is the BMI for that height and weight.

BMI (kg/m ²)	19	20	21	22	23	24	25	26	27	28	29	30	35	40
Height (in)														
58	91	96	100	105	110	115	119	124	129	134	138	143	167	191
59	94	99	104	109	114	119	124	128	133	138	143	148	173	198
60	97	102	107	112	118	123	128	133	138	143	148	153	179	204
61	100	106	111	116	122	127	132	137	143	148	153	158	185	211
62	104	109	115	120	126	131	136	142	147	153	158	164	191	218
63	107	113	118	124	130	135	141	146	152	158	163	169	197	225
64	110	116	122	128	134	140	145	151	157	163	169	174	204	232
65	114	120	126	132	138	144	150	156	162	168	174	180	210	240

66	118	124	130	136	142	148	155	161	167	173	179	186	216	247
67	121	127	134	140	146	153	159	166	172	178	185	191	223	255
68	125	131	138	144	151	158	164	171	177	184	190	197	230	262
69	128	135	142	149	155	162	169	176	182	189	196	203	236	270
70	132	139	146	153	160	167	174	181	188	195	202	207	243	278
71	136	143	150	157	165	172	179	186	193	200	208	215	250	286
72	140	147	154	162	169	177	184	191	199	206	213	221	258	294
73	144	151	159	166	174	182	189	197	204	212	219	227	265	302
74	148	155	163	171	179	186	194	202	210	218	225	233	272	311
75	152	160	168	176	184	192	200	208	216	224	232	240	279	319
76	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Obesity Treatment Requests

The AP must advise the insurer how obesity is delaying recovery. The AP's medical justification must show:

- The worker is severely obese.
- The worker's weight and level of function prior to the injury and how it has changed since the injury.
- Obesity is the primary condition impeding recovery from the accepted condition.
- Weight loss is necessary to undergo required surgery, participate in physical rehabilitation, or return to work.

Prior to authorizing an obesity treatment program, the AP and worker are required to develop a treatment plan. The insurer may also choose to have all parties sign an authorization letter, which serves as a memorandum of understanding between the insurer, worker, and attending provider regarding expectations of the treatment plan. The treatment plan must include:

- The amount of weight (average one to two pounds per week) the worker must lose.
- The estimated length of time needed for the worker to lose the weight.
- A diet and exercise plan, including a weight loss goal, approved by the AP as safe for the worker. The AP may request a consultation with a certified dietitian to determine if an obesity treatment program is appropriate for the worker.

- The specific program or other weight loss method requested.
- The AP's plan for monitoring weight loss.
- Documented weekly weigh-ins.
- Group support facilitated by trained staff.
- Counseling and education provided by trained staff.
- No requirements to buy supplements or special foods.

Obesity Treatment Not Payable

The insurer does not pay for:

- Surgical treatments of obesity.
- Drugs or medications to assist in weight loss.
- Special foods (including liquid diets), supplements, or vitamins. (See [WAC 296-20-03002](#).)
- Educational material, such as food content guides or cookbooks.
- Food scales or bath scales.
- Exercise programs or exercise equipment.

If a request is received for these types of treatment, the self-insurer must deny the requested treatment in writing as outlined in [WAC 296-15-425](#).

Obesity Treatment Approved

When obesity treatment is approved, the self-insurer must communicate the treatment authorization in writing as outlined in [WAC 296-15-425](#).

Once the obesity treatment is authorized, the AP must monitor and document the weight loss every 30 days. The AP notifies the insurer when:

- The worker reaches the weight loss goal.
- Obesity no longer interferes with recovery from the accepted condition.
- The worker is no longer losing the weight needed to meet the weight loss goal in the treatment plan.

Treatment should be authorized in 90-day blocks, as long as the worker:

- Continues to lose **an average** of 1 to 2 pounds each week.
- Pays the joining fee, continues to pay the weekly membership fee and obtains reimbursement by the insurer.
- Regularly attends the treatment sessions (meetings and weigh-ins).
- Sends the insurer the weekly weigh-in sheet signed by the specific program coordinator every week.
- Is evaluated by the AP at least every 30 days.
- Cooperates with the approved obesity treatment plan.

The insurer stops authorizing obesity treatment when **any** of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan.
- Obesity no longer interferes with recovery from the accepted condition. (See [WAC 296-20-055](#).)
- The worker is not losing weight at **an average** of 1 to 2 pounds each week.
- The worker is not cooperating with the approved obesity treatment plan.

Payment of Medical Bills

The insurer pays for proper and necessary services related to the diagnosis and treatment of accepted conditions ([WAC 296-20-01002](#)).

The insurer must adjudicate bills in accordance with the Washington State Industrial Insurance Laws, Medical Aid Rules, Maximum Fee Schedules, Provider Bulletins, Coverage Decisions, and Payment Policies ([WAC 296-15-330\(1\)](#), [WAC 296-20-01002](#)).

Adjudication of Bills

[WAC 296-20-010\(2\)](#), [WAC 296-20-125\(9\)](#), [WAC 296-15-330\(3\)](#), [WAC 296-20-01010](#), [WAC 296-20-015](#)

Providers must bill their usual and customary fee for services rendered.

The insurer must:

- As of date of service 1/1/13, for attending providers, only pay those who practice:

- In Washington State and are enrolled in the Medical Provider Network.
- Out of state and have an active Provider Account with the department.
- Pay the maximum allowable fee as set by the department if the provider's usual and customary fee is more than the maximum allowable fee.
- Pay the amount billed if the provider's usual and customary fee is less than the maximum allowable fee.
- Give the provider an explanation for nonpayment or for payment below the maximum allowable fee. An explanation is not required if payment is made according to the maximum allowable fee.
- Pay within 60 days of receipt of a proper bill or interest begins to accrue. If a proper bill is received prior to claim allowance, pay within 60 days of claim allowance. Interest must be paid at the rate of 1% per month, but at least one dollar per month ([RCW 51.36.085](#), [Self-Insurance Medical Bill Interest Calculator](#)).

Out of State Providers

[WAC 296-20-022](#), [WAC 296-20-015](#)

All health care service providers, regardless of their geographic location, are paid according to the Washington State Industrial Insurance Laws, Medical Aid Rules, Fee Schedules, Provider Bulletins, Coverage Decisions, and Payment Policies. Out of State providers are not currently required to join the department's Medical Provider Network; however, they must have an active Provider Account with the department in order to treat and receive payment.

Bills Paid by the Worker or Another Party

[WAC 296-20-020](#)

In situations of questionable eligibility when the worker and/or their private insurance paid for medical services now covered under the claim, the insurer should:

- Request itemized billings and reports from the providers.
- Pay the maximum allowable fees.
- Inform the providers of their obligation to refund the worker and/or private insurer in full.

No-show fees for missed appointments ([WAC 296-20-010](#)(6), effective 3/23/2012) – Other than missed appointments for examinations scheduled by the insurer, a provider may bill a worker for a missed appointment if the provider:

- Has a missed appointment policy that applies to all patients, and
- Routinely notifies all patients of the policy.

For information on No-Show Fees for an IME see the [Miscellaneous Claim Issues](#) chapter.

Rejected and Closed Claims

[WAC 296-20-124](#), [WAC 296-20-03005](#)

No payment is allowed for treatment or medication on rejected/denied claims except for:

- Services specifically requested by the insurer.
- Examination or diagnostic services used as a basis for the adjudication decision.
- Testing protocols and immunological treatment for exposure claims without injury.

Services rendered after the date of claim closure are not payable except for:

- Repair/replacement of durable medical equipment purchased under the claim.
- Examinations and diagnostic studies used for determination of claim reopening.
- Medical surveillance examinations for workers with closed claims for asbestos-related disease.
- Services specifically requested by the insurer.
- Testing protocols and immunological treatment for exposure claims with injury.

Physical Medicine

Massage Therapy

[WAC 296-23-250](#)

Massage therapy (MT) is a therapeutic treatment in which the muscles are rubbed and manipulated to relieve local pain and for relaxation. It is used in restoring range of motion and in reducing pain and medication usage by stimulating muscles and tissues to promote better circulation and the healing process. MT is a covered physical medicine service when requested by the attending provider, or their physician's assistant, and provided by a licensed massage therapist or other provider whose scope of practice includes massage techniques.

A progress report must be sent to the AP and insurer following six treatments or one month, whichever comes first. MT beyond the initial six treatments will be authorized based on

substantiation of improvement in the worker's functional capacities. Progress report must include the treatment plan, specific goals, and length of treatment.

Physical Therapy

[WAC 296-23-220](#)

Physical therapy (PT) uses physical agents such as water, heat, cold, massage, electricity, ultrasound, and exercise in the management of injuries. Physical therapists assess the current level of function and degree of dysfunction. They establish long and short-term goals and appropriate treatment plans. They conduct frequent evaluations of progress and update the plans and goals, when indicated.

PT should always involve training and treatment so workers may reach their maximum potentials. It is the physical therapist's responsibility to provide care that results in a beneficial outcome, while not providing treatment more frequently or longer than medically necessary.

PT or physical medicine services may be provided on a claim only by the following providers ([WAC 296-21-290](#)):

- Medical or osteopathic physicians who are board certified or board qualified in physical medicine and rehab (physiatrists).
- Licensed physical therapists (LPT).
- PT assistants employed by and serving under the direction of a registered physical therapist (RPT), a physical medicine and rehabilitation physician, or attending provider.
- Attending providers, within the following limited situations:
 - Attending provider's scope of practice includes physical medicine modalities and procedures.
 - A maximum of six PT visits in the attending provider's office. If the worker requires treatment beyond six visits, they must be referred to a physiatrist or RPT for further PT services.
 - In remote areas, when a physiatrist or RPT is not available within a reasonable distance.

Pool therapy and exercise classes supervised by an RPT can be allowed. However, membership at health spas or other similar facilities and home exercise equipment are not payable ([WAC 296-20-03002](#)). In addition, the insurer will not pay for services provided by exercise physiologists, kinesiologists, athletic trainers, aides, or other unlicensed personnel.

Twelve PT treatments may be allowed without prior authorization ([WAC 296-20-030](#)). However, the therapy needs to be prescribed by the attending provider for the accepted condition, and the therapist must provide the initial evaluation and a treatment plan.

Authorization for additional services is dependent on documentation of the attending provider's prescription for additional treatment and objective documentation showing that the worker's condition is improving. The self-insurer must communicate further treatment authorization or denial in writing as required by [WAC 296-15-425](#).

PT providers must submit monthly PT progress reports to the AP and insurer following 12 treatments or one month, whichever comes first. PT beyond the initial 12 treatments will be authorized only upon substantiation of improvement in the worker's condition. Progress reports must include the treatment plan, expected restoration goals, and the length of treatment required ([WAC 296-23-220](#)).

Occupational Therapy

Occupational therapy (OT) is the use of purposeful activities for acquiring the knowledge, skills, and attitudes necessary for the performance of life tasks, such as eating, working, playing, and caring for oneself. OT helps workers who survive catastrophic physical injuries, such as head injuries and amputations, lead meaningful lives despite considerable limitations in their abilities. The rules for OT are very similar to those for PT and are outlined in [WAC 296-23-230](#).

Work Conditioning

Work conditioning is a work-related, intensive, goal-oriented treatment program specifically designed to restore a worker's systemic, neuro-musculoskeletal, and cardiopulmonary functions. Generally, work conditioning is used to bridge a gap between acute outpatient therapy and a structured work hardening program or return to work. Work conditioning is not recognized by L&I as a special program and is covered according to the rules for outpatient physical therapy ([WAC 296-23-220](#)) and occupational therapy ([WAC 296-23-230](#)).

Work Hardening

[WAC 296-20-12050](#), [WAC 296-23-235](#)

Work hardening is a highly structured, goal-oriented, individualized treatment program designed to return a person to work. Work hardening programs, which are interdisciplinary in nature, use real or simulated work activities designed to restore physical, behavioral, and vocational functions. Work hardening addresses the issues of productivity, safety, physical tolerance, and worker behaviors.

Work hardening programs require prior approval by the worker's AP and prior authorization by the insurer. The self-insurer must communicate treatment authorization or denial in writing as required by [WAC 296-15-425](#). Only L&I-approved work hardening providers will be paid for work hardening services. More information about work hardening programs, including a list of

approved providers, criteria for admission into a program, and program standards is available on L&I's [web site](#).

Functional Capacity Evaluation

Functional capacity evaluations (FCEs) – previously called physical capacity evaluations – are assessments of a worker's functional physical capacities. They should include return to work recommendations and assist with the clarification of physical abilities if the AP has not provided enough information. FCEs should take into consideration the effects of the injury and any pre-injury limitations which affect performance.

FCEs can be useful when:

- Information indicates there may be some capacity to return to work, but the limitations are not clear. Light duty work is available but the insurer is not able to determine if the worker is able to perform the duties.
- A reasonable amount of time has passed to allow for recovery from a specific type of injury or condition.
- The AP indicates there are significant physical restrictions, which are not clearly documented in the medical information received.

Mental Health Treatment

[WAC 296-14-300](#), [WAC 296-21-270](#)

There is a natural impact on the mental health of any worker who has been seriously injured and/or unable to work for a long period of time. Some workers have mental health problems of various degrees which may or may not be related to the industrial injury or occupational disease. Each person reacts differently to a situation.

Treatment may be authorized for mental health conditions caused or aggravated by an accepted condition. Mental conditions with pain as primarily a psychiatric symptom (e.g. somatic symptom disorder) are specifically excluded from coverage based on [WAC 296-14-300](#)(3) and should not be accepted under a claim. The same applies to conditions characterized by abnormal thoughts or behaviors (e.g. conversion disorder). Temporary treatment may be authorized for these conditions if medically appropriate.

Temporary treatment for unrelated conditions can be allowed if the mental health condition causes a delay or prevents recovery of an allowed industrial condition ([WAC 296-20-055](#)). However, unrelated conditions are NOT the responsibility of the insurer. The insurer stops payment for temporary treatment of unrelated conditions when:

- The allowed industrial condition is resolved, or

- The allowed industrial condition is no longer delayed from recovery by the unrelated mental health condition(s).

Providers treating mental health conditions allowed on a claim need to submit progress reports to the insurer and to the attending provider every sixty days ([WAC 296-21-270](#)). If temporary treatment has been authorized for an unrelated mental health condition, progress reports need to be submitted to the insurer and attending provider every thirty days ([WAC 296-20-055](#)).

Who Can Treat

Mental health services must be provided by a psychiatrist, a licensed clinical psychologist (PhD, PsyD), or a psychiatric advanced registered nurse practitioner (ARNP). Psychological testing can be administered by their staff. However, the supervising psychiatrist, licensed clinical psychologist, or psychiatric ARNP must interpret the testing and prepare the reports.

A psychiatrist or psychiatric ARNP may be the attending provider and certify time-loss compensation if a mental health condition has been allowed and is the only condition still being treated. A psychiatrist may also rate permanent partial disability for mental health conditions. A psychiatric ARNP may not rate permanent partial disability or perform an independent medical examination. A clinical psychologist cannot be the attending provider and may not certify time-loss compensation, sign the Provider's Initial Report, or rate permanent partial disability.

For psychiatrists and psychiatric ARNPs, the treatment plan may include prescribing medications. The psychiatrist or psychiatric ARNP may prescribe medication either as the attending provider or when providing concurrent care ([WAC 296-20-071](#) "Concurrent Treatment" and [WAC 296-21-270](#) "Mental health Services").

Providers are expected to comply with the department's [Authorization and Reporting Requirements for Mental Health Specialists](#), available online.

Authorizing a Mental Health Evaluation

The authorizing of a mental health evaluation does not mean that the mental health condition has to be accepted under the claim. The evaluation is a one-time examination to see if a condition is present, if it is related to the injury, and if it needs treatment.

In addition to the reporting requirements listed in [WAC 296-20](#), the initial mental health evaluation should contain the information required by [WAC 296-21-270](#), including:

- Testing results with scores, scales, and profiles.
- Raw data sufficient to allow reassessment by a panel or independent medical examiner.
- Use of the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) format.

- Use of the SOAP (subjective complaints, objective findings, assessment of the worker's condition, and treatment plan) format.

American Psychiatric Association DSM-5 Manual

The American Psychiatric Association has developed the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition), commonly referred to as the DSM-5. The reporting requirements no longer allow the use of the DSM-IV manual. The DSM-5 manual includes diagnostic and etiological criteria used for each mental health condition, along with an appropriate specifier (severe, mild, etc.).

When reporting on mental health conditions, providers should include the following elements:

Diagnosis – Diagnosis should be specific and use the diagnostic criteria identified in the DSM-5. More than one diagnosis may be listed. Standardized instruments should be used to measure symptom severity for mental health conditions (e.g., PHQ-9 or BDI for depression, GAD-7 or BAI anxiety). Diagnoses may include unrelated conditions, such as personality disorders or developmental disorders. The criteria for these diagnoses should be outlined as with other diagnoses, as they are long-standing and not occupationally-related but could be exacerbated or increased by the injury.

Return to work considerations – The provider must comment on the worker's ability to work as it relates to the condition(s) being treated. Information should include specific examples of a worker's mood, behavior, cognitive function, energy levels, daily activities, or other limitations. Job modifications or work restrictions may include: reducing distractions in the work area, dividing large assignments into smaller tasks and goals, allowing additional time to learn new responsibilities, or allowing a modified break schedule and/or flexible work hours.

Identification of barriers to recovery from the industrial injury – Each mental health condition should be assessed to determine whether it is retarding a worker's recovery from an accepted physical condition and any barriers should be clearly identified. Psychosocial and environmental problems may be related to the worker's primary support group, social environment, education, occupation, housing, economic situation, access to health care, and interaction with the legal system or crime. Positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, such as when a worker has difficulty adapting to a new situation.

Identifying barriers can be highly instrumental in determining the cause of the mental health condition. There may be other factors, such as a death in the family, which are contributing or have contributed to the worker's mental health status.

Documenting a treatment plan – Special emphasis should be given to functional recovery. The treatment plan must identify specific functional goals, recommend duration of treatment, and target specific symptoms. The provider should identify which variables will be measured to assess progress (e.g. improved score on PHQ-9 or BDI). The initial 90-day authorization period must be intensive, with at least 10-12 visits.

For treatment plans involving medication, the worker's current medications should be reviewed for any possible drug interactions.

Assessment of functional status – The worker's status should be assessed every 30 days using the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0). This is a standardized and validated instrument for assessing disability and is very helpful in tracking improvement in a worker's perceived disability. It can be self-administered or given by the provider. A copy of the completed and scored WHODAS 2.0 form must be sent to the insurer and attending provider with the 30-day or 60-day reports ([WAC 296-21-270](#)).

Mental Health Services

The following mental health services are **payable**:

- Medication.
- Individual psychotherapy.
- Group psychotherapy. (This may be authorized on a case-by-case basis, but only as part of the worker's treatment plan, not as the primary component of the plan.)
- Therapy sessions that include the worker's support system (family, significant other, etc.).
- Narcosynthesis and electroconvulsive therapy.
- Hypnotherapy.
- Biofeedback ([WAC 296-21-280](#)).
- A combination of these items.

The following mental health services are **not payable**:

- Interactive psychiatric interview/exam and interactive psychotherapy – Interactive psychotherapy is typically for children. It involves the use of physical aids, play equipment, language interpreter, or other mechanisms of nonverbal communication.

- Psychoanalysis – Psychoanalysis is the therapy technique originated by Sigmund Freud. The technique explores mental processes by using free association, dream interpretation, and analysis of resistance and transference.
- Family psychotherapy without the patient present.
- Multiple family group psychotherapy.

When a request for mental health treatment is received, the self-insurer must communicate treatment authorization or denial in writing as required by [WAC 296-15-425](#).

Mental Health Confidentiality Requirements

The confidentiality of all claim records and records of employment is protected by law. It is the responsibility of the employer to maintain this confidentiality. All records, payrolls, and books are subject to L&I's inspection and verification.

Revealing of Mental Health Conditions or Treatment – Employers should only share workers' compensation claim information with people who are authorized. Examples of people employers can communicate with about the claim are:

- The worker or their representative.
- The employer's authorized representatives.
- Medical providers treating or examining the worker.
- Vocational Rehabilitation Counselors.
- Authorized L&I personnel.

Employers are subject to a civil penalty of \$1000 per occurrence for revealing claim file information about mental health conditions or treatment to anyone except authorized representatives.

Examples:

Example 1: An employer sends an electronic correspondence to three people unauthorized to receive claim information. The correspondence shares a worker's mental health condition from the claim file. Since the information was sent through one electronic correspondence, the employer will be charged for one occurrence.

Example 2: One of the unauthorized people in Example 1 forwarded the electronic correspondence to an unauthorized person the next morning. Later that afternoon, that same person sent an additional correspondence to another unauthorized person. Since the unauthorized person sent the mental health information to other unauthorized people on two separate occasions, the employer will be charged for two additional occurrences.

Example 3: On three separate occasions an authorized representative verbally shares mental health information from a worker's claim file with three different unauthorized people. Since the

information was shared in three separate conversations, the employer will be charged for three occurrences.

All complaints from the worker regarding this violation must be investigated to determine if the employer or their authorized representative violated [RCW 51.28.070](#).

Specialized Equipment

Special equipment or devices can be authorized as a temporary treatment measure or may be purchased for use on a permanent basis. If a claim is closed, it is not necessary to reopen the claim to repair or replace permanent equipment. If one or two office visits are needed for fitting, payment can be allowed without reopening the claim.

Travel required to repair, replace, or otherwise alter prosthetics, orthotics, or similar permanent mechanical appliances after closure of a claim is payable. This does not include travel for repair or replacement of hearing aids ([RCW 51.36.020](#)(5)).

Equipment not requiring prior authorization are items such as back braces, cervical collars, rib belts, crutches, canes, and other commonly used orthotics of minimal cost ([WAC 296-20-1102](#)).

The following references provide additional information:

- Closed claims – [WAC 296-20-124](#)
- [Condition and Treatment Index](#) – Select the treatment or condition for additional information about billing and related rules.
- Eye glasses – [WAC 296-20-100](#)
- Hearing Aids – [WAC 296-20-1101](#)
- Miscellaneous services and appliances – [WAC 296-23-165](#)
- Payment Policies on Durable Medical Equipment – found under the appropriate [Fee Schedule](#) for the year you need.
- Special equipment rental and purchase – [WAC 296-20-1102](#)
- Transportation – artificial substitutes and mechanical aids – [RCW 51.36.020](#)
- Treatment requiring authorization – [WAC 296-20-03001](#)(9)

Surgery

Surgery Authorization Requests

Requests for authorization must include a statement of:

- Condition(s) diagnosed.
- ICD-10 codes, including their relationship to the industrial injury/exposure.
- An outline of the proposed treatment program, including its length and components.
- Procedure codes.
- Expected prognosis and an estimate of when treatment would be concluded and condition stable.

If the surgery requires hospital admission, the self-insurer must notify the worker and provider of treatment authorization or denial as required by [WAC 296-15-425](#).

Consultations for Second Opinions

[WAC 296-20-045](#)

A consultation with a qualified provider with experience and expertise on the subject is required prior to authorization of surgery in the following situations:

- Nonemergency major surgery on a patient with serious with serious medical, emotional, or social problems which are likely to complicate recovery.
- Procedures of a controversial nature or type not in common use for the specified condition.
- Surgical cases where there are complications or unfavorable circumstances such as age, preexisting conditions, interference with occupational requirements, etc.

Surgery for Preexisting Conditions Aggravated by the Industrial Injury or Disease

Authorization for surgery might be requested for conditions which pre-existed the injury or were treated prior to the injury. The attending provider should be contacted and asked whether the surgery is needed as a result of the industrial injury or is due to the natural progression of the preexisting condition.

Example: An injured worker had a previous total hip replacement which has become aggravated by the injury, and a new hip replacement is requested.

If the surgery requires hospital admission, the self-insurer must notify the worker and provider of treatment authorization or denial as required by [WAC 296-15-425](#).

Tobacco Cessation

Smoking or other tobacco use does not meet the definition of an industrial injury or occupational disease, and it should not be accepted under the claim. Tobacco cessation treatment may be authorized prior to surgery as an aid to recovery if certain criteria are met.

Tobacco cessation treatment should be covered for planned surgeries when all of the following criteria are met:

- The worker uses tobacco product(s) (cigarettes, pipes, cigars, smokeless tobacco) on a regular basis.
- Tobacco cessation treatment has not previously been paid on the claim, *or if it has*, an exception for repeat treatment has been made based on individual claim review.
- The provider recommends tobacco cessation treatment, OR L&I's medical treatment guideline for the surgery recommends OR requires tobacco cessation treatment prior to surgery
- A worker meets the surgical criteria in L&I's medical treatment guideline when authorization for a planned surgery is requested.

The guidelines for cervical fusions, lumbar fusions, and rotator cuff repairs either recommend or require tobacco cessation prior to surgery. These guidelines and additional rules are available on the [Tobacco Cessation for Surgical Care](#) coverage decisions web page.

Treatment During Protest or Appeal

When handling a claim that has an active protest/appeal, the insurer needs to review the claim to determine the status and issue of the protest or appeal. Claims may be in a protest/appeal status for a variety of reasons, and ongoing treatment may continue in some cases.

It may be necessary to file a motion for a stay of medical benefits during an appeal. For more information, see the Pay During Appeal matrix in the [Protests and Appeals](#) Claims Adjudication Guidelines.

Treatment Not Authorized

[WAC 296-20-03002](#)

The following treatment is not authorized:

- Use of diapulse, thermatic (standard model only), spectrowave, and superpulse machines.
- Iontophoresis, prolotherapy, acupuncture, injections of fibrosing or sclerosing agents, injections of substances other than anesthetic or contrast into the subarachnoid space (intrathecal injections).
- Treatment to improve or maintain general health, including prescriptions and/or injection of vitamins, or referrals to special programs such as health spas, swim programs, exercise programs, athletic-fitness clubs, diet programs, or social counseling.
- Continued treatment beyond stabilization of the industrial condition(s), i.e., maintenance care, except where necessary to monitor prescription of medication to maintain stabilization, (anti-convulsive, anti-spasmodic, etc.).
- Any treatment measure deemed to be dangerous or inappropriate for the injured worker.
- Treatment measures of an unusual, controversial, obsolete, or experimental nature. Under certain conditions, the insurer may approve treatment in this category (see [WAC 296-20-045](#)). Requests must contain a description of the treatment, the reason for the request, and the benefits and results expected.

Additional treatment that is not authorized can be found in the [Condition and Treatment Index](#) on L&I's website.

If an authorization request is received for treatment determined to be non-covered, the insurer should immediately advise all concerned parties that it is not authorized.

If the injured worker persists in receiving, or has already received treatment which is non-covered, the insurer should advise all concerned parties that they will not accept responsibility for any conditions, residuals, or complications to the accepted condition arising from non-covered treatment.

If the worker is unable to work due solely to complications or conditions resulting from non-covered or unauthorized treatment, time-loss compensation is not payable.

Treatment on Pension Cases

[RCW 51.36.010](#)

Coverage for medical treatment ends on the day before the pension goes into effect. An exception is made in some cases where continued treatment is needed to protect a worker's life. This is discussed under Medical Coverage in the [Pension and Fatalities](#) section of the Claims Adjudication Guidelines.